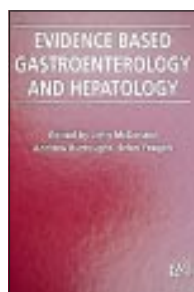


# reviews

BOOKS • CD ROMS • WEBSITES • MEDIA • PERSONAL VIEWS • SOUNDINGS • MINERVA

## Evidence Based Gastroenterology and Hepatology

Eds John McDonald, Brian Feagan, Andrew Burroughs



BMJ Books, £65, pp 572  
ISBN 0 7279 1182 1

Rating: ★★★

The purpose of evidence based medicine is to help doctors to keep up with the expanding scientific basis of medicine and to apply it to individual patients. In this regard *Evidence Based Gastroenterology and Hepatology* clearly addresses a need, especially for those who

need to be at the cutting edge of medical sciences, such as scientists, teachers, and opinion leaders. It will be ideal if selected topics have to be discussed at a high scientific level, and will also be useful for doctors looking for confirmation of their opinions and biases—but beware, these may be scientifically proved to be wrong.

Like every good tool, evidence based medicine can be misused, and we don't mean the medical student who uses it to embarrass his or her teacher after having read up on a specific topic. Readers have to be careful not to overinterpret its role in daily medical practice. Evidence based medicine does not provide cookbook-style recipes to deal with medical problems, as the editors correctly point out in the introduction.

A study of poor scientific quality may still be clinically important. Although large multicentre randomised trials are thought to provide the highest level of scientific evidence, their inclusion criteria are usually so stringent that it is questionable how applicable their conclusions are to a typical patient seen in practice. Therefore, no one

using this book should skip its first chapter, which provides thorough guidance on how to apply evidence based medicine to the care of individual patients. Evidence based medicine does not release doctors from their responsibilities, but it can help them to consider different options. In this context, this book, if used carefully, may also be very useful for practising doctors.

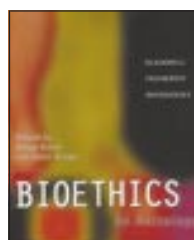
Those intending to use this text to update themselves on the current scientific evidence must remember that even a book dealing with evidence may contain bias, in the selection of topics and the presentation of evidence and interpretation of its scientific strength. This book certainly does not encompass the whole range of gastroenterology and hepatology, but, for those topics that it does cover, it provides an excellent reference to the current scientific knowledge.

**Heinz F Hammer** *associate professor of internal medicine*

**Andreas Eherer** *attending physician, Department of Internal Medicine, Division of Gastroenterology and Hepatology, University of Graz, Austria*

## Bioethics: An Anthology

Eds, Helga Kuhse, Peter Singer



Blackwell Publishers, £18.99,  
pp 600  
ISBN 0 631 20311 7

Rating: ★★

Peter Singer was a keynote speaker at the last annual meeting of the American Society of Bioethics and Humanities in Philadelphia. For various reasons, I had chosen this moment in the programme to duck out of the conference. I was completely unprepared for what greeted me as I left the hotel—protesters, many confined to wheelchairs, chanting “Less debate, more hate.” This, I discovered, was the disability activist group Not Dead Yet, which is incensed about Singer's stance that some people with disabilities are not “persons” and may be killed or allowed to die with impunity. It is rare for philosophers to incite the ire of the community at large. Socrates

and Bertrand Russell did, and now it seems Peter Singer has joined the ranks of infamy.

I am disappointed by Kuhse and Singer's edited collection of philosophical papers on bioethics. The selection is deeply conservative, and it eschews literature at the margins of bioethics. This is a shame because contemplation of narrative ethics, anthropology, families, and communities is where the action has been in bioethics during the past decade. My attention was naturally drawn to the four essays by Singer himself in the volume. Here, I was not disappointed but offended. Singer variously concludes that experimenting on a human embryo is preferable to doing so on a mouse; that chimpanzees are properly called “people,” but humans with profound cognitive impairments are not; and the heart of a handicapped newborn human might be legitimately excised to save a baboon in need of a new heart. Some have argued that Singer is not responsible for these absurd conclusions since he is merely working through the logical outcomes of a particular moral theory, utilitarianism. Whatever faults we may find with the outcome are properly attributed to the theory and not the philosopher. I disagree: Singer is culpable for these views because doing ethics responsibly involves more than logical reasoning alone. Moral intuition acts as an important check on ethical reasoning, telling us that at times it is the theory, not our actions, that must be

changed. More than once Singer notes, “At first this sounds crazy,” and more than once he fails for not paying attention to his own intuition.

My reaction to Singer's work is akin to discovering that a friend has served me her pet for dinner. As my initial reaction of disgust fades, I would wonder whether the animal was really a pet, and, if it was, whether my friend actually understands what it means to have a pet. Having a pet implies a set of rules describing the proper relationship between owner and pet—and not eating one's pet is high on the list. The terms “person” and “animal” come with their own sets of rules, embedded deep within our society, defining relationships among human beings and between people and animals. Singer, in suggesting that these terms or the rules associated with them may be interchangeable, demonstrates that he fails to understand the concepts of “person” and “animal” at all.

**Charles Weijer** *bioethicist, Dalhousie University, Halifax, Canada*

The BMJ Bookshop will endeavour to obtain any books reviewed here. To order contact the BMJ Bookshop, BMA House, Tavistock Square, London WC1H 9JR.

Tel: 020 7383 6244, Fax: 020 7383 6455

email: [orders@bmjbookshop.com](mailto:orders@bmjbookshop.com)

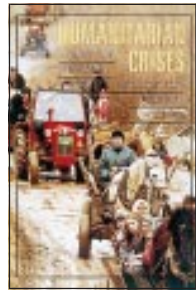
Online: [bmjbookshop.com](http://bmjbookshop.com)

(Prices and availability subject to change by publishers.)

*Reviews are rated on a 4 star scale  
(4=excellent)*

## Humanitarian Crises: The Medical and Public Health Response

Eds Jennifer Leaning, Susan M Briggs, Lincoln C Chen



Harvard University Press,  
£27.95, pp 379  
ISBN 0 674 15515 7

Rating: ★★★

Call me a misery, but the passing of the 20th century—in which war and genocide claimed over 150 million people—might more properly have been marked by a requiem mass than by all the razzmatazz. Between 25 and 40 wars were active at any one time in the 1980s and 1990s, almost all “internal” and principally targeting civilians and their ways of life. Most of the arms used in these wars came from members of the United Nations Security Council, an apt commentary on the moral economy prevailing in the elite nations of the world. The modest advances in the

world's poorest societies in the decades up to the 1970s—evident in mortality and morbidity statistics, child nutrition, access to schooling, etc—have largely been wiped out.

During the flight to Goma in 1994, death rates among Rwandans were 60 times baseline rates; 65% of deaths among Kurdish refugees on the Turkish border were in children aged under 5 years. In conditions of war malnutrition, measles, and diarrhoea make a lethal combination; even when “peace” comes, public health consequences roll on as a function of poverty and a shattered social infrastructure. Today, nearly 1 in 100 of the global population is a refugee or is otherwise displaced (a sixfold increase in a generation).

Paralleling these trends has been a burgeoning in the global humanitarian industry, with spending on emergencies peaking at \$7.2bn in 1994. *Humanitarian Crises*, a substantial multiauthor compilation from the United States, is written for those in the public health and medical communities involved in relief efforts. It covers key public health issues in assessment and intervention; mental health; ethical, legal, and practical dilemmas in the field; and the often problematic relation between relief efforts and military operations.

In a strong introduction Jennifer Leaning points out that nation states and the United Nations have seen peacekeeping

forces as a means of avoiding proper responsibility, and that relief workers in former Yugoslavia were bitter about the part the UN played in helping to feed people one day so that they could be shot by snipers the next. (In Sarajevo I was told that people dismissively called this model of humanitarian aid “bread and counselling.”)

What is called “disaster mental health”—a term that may be an oxymoron—is an emergent fashion, trading on Western psychological concepts and technologies (like “post-traumatic stress” and “debriefing”) as if they had proved track records even in Western disasters. None the less, Richard Mollica writes interestingly on the dynamics of psychosocial disability and resilience. There follows a lengthy chapter on psychological trauma in relief workers—something of a non-issue in my view.

The latter sections of the book use case examples and tables effectively to look at the way that relief operations can be drawn into the dynamics of complex emergencies and not necessarily be regarded as neutral. There is brief review of the role of the “humanitarian” military in northern Iraq (partial success), Somalia (disaster), and Rwanda (too little, too late).

**Derek Summerfield** *psychiatrist, Medical Foundation for the Care of Victims of Torture, London*



## Blue/Orange

Cottesloe, National Theatre, London  
Until 17 June 2000

Society is curious about psychiatry. In Kevin Kesey's *One Flew Over the Cuckoo's Nest* and the recent British television series *Psychos*, dramatists explored the meaning of mental illness and its treatment. The writer Joe Penhall tackled the subject of psychiatric care in the community in his award winning play *Some Voices*, and he follows it with his new play *Blue/Orange*.

The Cottesloe Theatre is perfect for the play, for its intimacy pulls the audience in to the claustrophobic hospital room in which three main characters interact. The cleverly crafted interplay between Christopher, a young black patient, and his two doctors, becomes emotionally charged early on in the evening. The story keeps you guessing about each of the characters' true intentions. All of their seemingly logical arguments become tainted, and we begin to suspect racism in the doctors' actions.

The play questions our criteria for the involuntary detention of patients under the Mental Health Act and raises doubts about the labelling of people with personality disorder. Christopher is in hospital against his will, and we witness the final day of his one month's evaluation period. The junior doctor, played by Andrew Lincoln from the acclaimed British television series *This Life*, tries hard to impress in his first ever psychiatry job. The consultant, played by Bill Nighy, initially questions whether black people diagnosed with psychiatric conditions are victims of a society that mistakes cultural differences for mental illness. However, more sinister aspects of his personality are soon revealed, leaving the audience guessing as to whether his actions are directed towards career advancement, are based on his own prejudices, or are truly in the interest of the patient. The debate intensifies, constantly challenging and frustrating the audience, while cleverly breaking the escalating tension with humorous moments.

Christopher is played by Chiwetel Ejiofor, who appeared in Stephen Spielberg's



A young black patient in a confusing world

*Amistad*, and the character finds himself caught up in the midst of this complex battlefield. As the drama unfolds, his claim to be the son of an exiled African dictator becomes unnervingly plausible, and we witness his fear of being trapped in a confusing world where no one seems to be in control.

*Blue/Orange* succeeds in raising the possibility that ethnic minorities are victims in the current psychiatric system, which was never designed to meet the needs of minority groups. Roger Mitchell has directed an intelligent, character driven story about race, madness, and a Darwinian power struggle at the heart of a dying NHS.

**Jason O'Neale Roach** *BMJ*

## PERSONAL VIEW

## The ethics of research ethics committees

Our health service research unit has been carrying out primary evaluative studies for over 30 years. Much of what we do is designed to help improve health care and health services and inform NHS decisions. It may not be fundamental science but it feels worthwhile, sometimes has an important impact, and we know that it is valued, particularly if the studies are done in a timely and nationally representative manner.

But as well as our ever shortening deadlines and increasing workloads we now find that we cannot do our jobs because of research ethics committees. I do not mean that our studies are unethical. Far from it, our studies are nearly always approved—eventually—but the time taken to get approval from several local research ethics committees (LRECs) and in overcoming bureaucratic and practical obstacles, rather than ethical problems, has become a barrier to our research.

The difficulties of obtaining ethical approval for multicentre research have been widely recognised. For example, we once finally received ethical approval from one hospital research ethics committee out of more than 20 that we had approached two years after our first application and only a few months before completion of the whole study. On another occasion, after several LRECs had approved a study, one refused. This refusal came after I had attended an evening LREC meeting 150 miles away when all the members present were happy to approve the project. One member, who was absent, later objected.

These difficulties were supposed to have been put behind us with the formation of multicentre research ethics committees (MRECs). The problems have continued and the MREC is now often the problem.

We had to make several submissions and there was a nine month delay in getting approval for a purely methodological study involving no intervention and anonymised data.

After written approval from an MREC and several LRECs a study was started, but the MREC wrote four months later withdrawing its approval.

One of three LRECs was unable to approve a population survey at the right time because the committee had moved offices and the original letter had gone astray. Despite the fact that the same LREC had approved our two identical, earlier, surveys, and the fact that the MREC had approved the study involving the third survey, the LREC did not think that this could be speeded up by taking chairperson's action.

The problem is not usually to do with any single ethics committee. It is more to do with the fact that any national study inevitably involves several LRECs from each of whom approval must be sought even with MREC approval. As each committee has its own distinct application form, its own idiosyncratic timetable, and there are often requests to appear 200 miles away, it is impossible to obtain permission from more than three committees in three months.

There is always one committee secretary on leave, or a chairperson who has resigned, or a letter that is lost, and a thousand and one other delays—all of which are genuine and

**For ethics committees to have become barriers to ethical research ... is certainly immoral**

understandable—but which add up to the impossibility of doing practical research in the NHS to help decisions which must be made promptly. The forms (13 copies please), which must be completed, are mind boggling. For our surveys of patients we are asked to list all the known toxic effects of

the questionnaire; for studies of deaths we are asked for our patient consent form; for a Medical Research Council study costing £750 000, approved after two years' consideration by several referees and involving many of the country's leading biostatisticians, we are asked for our sample size calculation.

The bureaucratic unhelpfulness of research ethics committee procedures might be bearable if the committees attended to the ethics of the studies they reviewed. In our experience they have been concentrating on scientific, legal, and confidentiality issues instead of ethical issues. Now that the Court of Appeal has made it clear that there is nothing wrong with having access to anonymised data we confidently expect other issues to begin to raise their heads—perhaps democratic issues of religious, ethnic, and cultural equality.

Of course, ethical issues are difficult. Notions of right and wrong vary; they change over time, and involve weighing the rights of individuals and society. In a rapidly changing, secular society it is sometimes hard even to identify the ethical issues. Computerised systems with formalised rules which researchers could take into account cannot be devised and would miss the essence of an ethical assessment, which is why science, the law, and confidentiality rules cannot equate to ethics. The idea of "Microsoft" ethics is neither feasible nor desirable. But for ethics committees to have become barriers to ethical research, which could help to improve health care, is certainly immoral.

**Jon Nicholl** *director, Medical Care Research Unit, University of Sheffield*

## SOUNDINGS

## The class reunion

They are strange things, class reunions. There is a certain fascination about them because, in the end, we measure our lives against our contemporaries. Those younger and older are of little interest in this game of comparisons. And so, at the 20 year get together, we find ourselves wandering around in evening dress, surreptitiously watching out of the corner of our eye for the blemishes, the feet of clay. The fellow with the paunch and the lined, careworn face does us all a service. We glance at him and whisper out of the corner of our mouths how old he looks. The initial impression is how little people have changed, until you remember that you are looking at them with eyes that are accustomed to the middleaged face in the shaving mirror.

My wife asked me if I enjoyed the reunion, but that is not quite the right term. It is one of those events, like funerals, that momentarily take you out of the comfortable monotony of the familiar. Each year there is some event that tolls the bell for another year. For me it is returning home on a frosty November night and seeing Orion for the first time in the winter black sky. For my wife, alas, it is doing the tax returns (a flicker of guilt there). But the once a decade event signals the passing of a serious fraction of your life expectancy and causes more than momentary reflection.

So how were they all, these people whose past was briefly entangled with your own? The surprising thing is the extent to which characteristics seem to stay invariant over half a lifetime. There is clearly a law of conservation of feistiness, a law of conservation of awkward English gangliness, a law of conservation of absurd high pitched laughs, and going into too much detail about your past (and possibly a correlation between the latter two variables). And the people who always described themselves in capital lettered clichés, broad brush stroke categories taken from self help books, still do. And then there are the people who, whatever they say, have let you glimpse the uniqueness of them, and you are glad to have met them again.

And overall you drive away in reflective mood, having taken time out of the normal flow of life to consider yourself. Any regrets? As Woody Allen said, "My only regret, is that I'm not someone else."

**Kevin Barraclough** *general practitioner, Painswick, Gloucestershire*